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AUTHOR Reynolds, Kathleen; Ogiba, Shawn; Chambliss, Catherine
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ABSTRACT

Training therapists effectively requires familiarizing them with the modal expectations that clients bring to the therapeutic encounter. Ways in which therapists can be apprised of clients' expectations of therapy are discussed. Accurate understanding of clients' attitudes permits development of appropriately focused therapy goals and is generally associated with higher client satisfaction at the end of treatment. Congruence between therapist and client objectives also reduces premature termination. Reasons for client termination have been studied primarily by use of therapists' retrospective assessment. In this study, it is hypothesized that one underlying factor for early termination may be an incongruence between client and therapist expectation of therapy. In order to assess congruence, 100 randomly selected mental health care professionals and prospective psychotherapy clients were surveyed regarding client expectations and goals of therapy prior to the onset of treatment. Areas of client therapist congruence are examined, and their implication for the conduct of effective psychotherapy are explored. Appendices include the Client Attitude Questionnaire and Client Motivations for Seeking Treatment. Contains 90 references. (Author/MKA)

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Educating Therapists in Training About Clients' Expectations of Treatment

Kathleen Reynolds

Shawn Ogiba

Catherine Chambliss, Ph.D.

Ursinus College

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C. Chambliss

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Abstract

Training therapists effectively requires familiarizing them with the modal expectations that clients bring to the therapeutic encounter. Accurate understanding of clients' attitudes permits development of appropriately focused therapy goals, and is generally associated with higher client satisfaction at the end of treatment. Congruence between therapist and client objectives also reduces premature termination. Reasons for client termination have been studied primarily by use of the therapists' retrospective assessment. In this study, it is hypothesized that one underlying factor for early termination may be an incongruence between client and therapist expectations of therapy. In order to assess congruence, one hundred randomly selected mental health care professionals and prospective psychotherapy clients were surveyed regarding client expectations and goals of therapy prior to onset of treatment. Areas of client therapist congruence are examined, and their implications for the conduct of effective psychotherapy are explored.

Introduction

Why do clients seek outpatient psychotherapy? Although this knowledge would seem to be fundamental to the development of successful helping strategies, relatively little empirical research has addressed this issue. Although the client-centered therapy tradition (Rogers, 1966) has long made consumer satisfaction and direction of the treatment process central, even those committed to this treatment orientation have rarely collected data on client's expectations of treatment.

Critics of various schools of therapy have long argued that treatments that fail to address the specific concerns of patients may be coherent conceptually, but of limited practical value. Premature termination and attrition from therapy outcome studies have often been attributed to a treatment's failure to conform to patients' expectations of psychotherapy, although patients who leave treatment early have rarely been interviewed to ascertain their exact reasons for departing.

According to Hill, Nutt-Williams, Heaton, Thompson and Rhodes (1996), patients often prematurely terminate therapy due to an impasse. The termination can be detrimental to patient and therapist. There is a need to understand more about the causes of an impasse so that therapists can deal with the problems effectively and reduce the number of ill effects on both therapists and clients.

An impasse is a deadlock or stalemate that causes therapy to become so difficult or complicated that progress is no longer possible and termination occurs (Atwood, Stolorow, & Trop, 1989; Elkind, 1992; Weiner, 1974). Lists of factors that may contribute to impasses have been compiled by clinicians based on their experience. There is little consistency among these lists and none have been validated. In one empirical study, Rhodes, Hill, Thompson, and Elliott (1994) studied clients' retrospective recall of resolved and unresolved misunderstanding events in therapy. The Rhodes study included only impasses that arose from misunderstandings, relied on client recall, had a small sample size and used a limited questionnaire.

Hill, Nutt-Williams, Heaton, Thompson, and Rhodes chose in this study to investigate the variables associated with impasses from the therapist perspective using questionnaire and interview data. The questionnaire consisted of : demographic information about the therapist, general questions about experiences with impasses, a request for information regarding a recent impasse, and demographic information about the client described in the impasse example. An impasse interview was conducted after the questionnaire was completed. This allowed clarification of items reported as well as providing other details. Five researchers participated in the analysis. Prior to

collecting data these researchers recorded their expectations about the outcome of the study.

The results show that impasses were characterized as involving general disagreement between therapist and client, being charged with negative emotion, and the termination coming as a surprise to the therapist. The impasses had a lingering effect on the therapists. Variables associated with the occurrence of impasses are stated as : the severity of client pathology, disagreement over goals, possible therapist mistakes, triangulation, transference, therapist issues, and the therapeutic relationship. Limitations given are: The study involved on therapists' perspectives, impasses were studied from recall instead of as they occurred, a small sample was used. It is suggested that future studies examine both therapist and client perspectives in the same study. An implication of the results of this study is that therapists need to be trained to be aware of the variables associated with impasses.

Congruence

Congruence between therapists' perceptions of clients' preferences and clients' actual preferences has been predicted to enhance treatment effectiveness. According to Fatima and Kivlighan (1993), an amenable client-counselor relationship is essential for successful therapy. Part of this relationship involves the different expectations that each party has regarding various aspects of therapy. A working alliance is one such aspect that has been the focus of past research. Bordin (1979) defined the working alliance as the collaboration between the client and counselor based on their agreement on the goals and tasks of counseling and on the development of an attachment bond. The working alliance is based on four different factors: client pretherapy characteristics, counselor personal characteristics, counselor technical activity, and how well the client and counselor fit together (Hartley & Strupp, 1982; Kivlighan, 1990; Kokotovic & Tracey, 1990). Past research has found that client's with a disposition towards affiliation and forming intimate relationships is positively associated with the work alliance (Moras & Strupp, 1982; Mallinckrodt, 1991; Keithly, Samples, & Strupp, 1980).

Closely related to the working alliance is the client-counselor expectations of their relationship. Berzins (1971) defined relationship expectations as the client's expectation (or the counselor's expecting the client to) spontaneously self-disclose in the context of a comfortable egalitarian relationship with the counselor. A few studies have found that most client relationship expectations increase from the first session of therapy onward and that it is indicative of a positive outcome (Sandler, 1975; Tracey & Dundon, 1988).

Fatima and Kivlighan hypothesized that higher levels of client or counselor expectations for relationship would be related to higher working alliance ratings. Additionally, they hypothesized that congruence in client and counselor relationship expectations would predict ratings of the working alliance after the effects of client and counselor relationship expectations had been controlled. They broke up the working alliance into three parts: bond, agreement on tasks, and agreement on goals. The sample size was composed of 25 counselor-client dyads from a counseling center and the measurements used were the Revised Psychotherapy Expectancy Inventory (PEI-R) and the Working Alliance Inventory (WAI). Their results supported their hypotheses. It was noted that relative congruence in expectations for relationship was not related to the alliance. This suggests that it is important that expectations of the relationship between the client and counselor match and little importance is given to whose expectations are higher or lower. Limitations of the study given were: that the expectations were derived from actual counseling experience and not from pretherapy, that their may have been biases involved by allowing the counselors to select the client to participate, and an underrepresentation of more experienced counselors in the sample.

Many variables can influence the results of research and the demographics of the population used are important to consider. Mallinckrodt and Nelson (1991) found that novice and experienced counselors differed in their ratings of work alliance. Although differences in expectations of relationship or work alliance were not linked to gender or race, such considerations are also important.

In outpatient settings, studies have shown that a collaborative relationship between patient and therapist in regard to therapy goals leads to greater benefit from therapy for the client. A few studies have extended research to inpatient settings. It is suggested that attention to therapeutic alliance can positively influence the outcome of treatment. Greenson, (1965) described several cases in which patients failed to improve until implicit expectations and methods of treatment were explicitly articulated. Kernberg et al., (1989) suggested that prior to therapy a treatment contract should be established.

A study by Lieberman et al. supports previous findings that a collaborative therapeutic alliance predicts patient improvement during psychiatric hospitalization. Shared commitment to goals of treatment was rated independently by staff and patients. The measures of alliance were made at the start of hospitprovement producing agreement. The hospitalization period for clients studied was brief and the effects of medication were taken into account. Forty eight patients were interviewed at admission and again at discharge. The patients completed standard questionnaires

measuring five dimensions that had been hypothesized to change during brief hospitalization (Lieberman et al. 1992). Measurements used in this study were: the Brief Psychiatric Rating Scale, the Global Assessment Scale, the Kaplan Self Esteem Scale, the Bond Defense Inventory, and the Ward Atmosphere Scale. At admission, patients were also asked to rate each of 10 functional areas in terms of how important each seemed as a goal during treatment. A second scale asked patients to rate how helpful or harmful they expected hospital staff to be in meeting their goals. Staff members were asked to complete the same questionnaire.

The results showed that the degree of patient-staff agreement on goals was not associated with any of the following: age, sex, number of prior admissions, presence of a major affective or psychotic disorder or a diagnosed personality disorder. Level of symptoms, self-esteem, defense style, expected helpfulness of staff on admission, and level of functioning at admission had no association with goals. Expected helpfulness of staff was uncorrelated with clinical and demographic variables. One exception was noted: at admission, women expected the staff to be of significantly greater help than did men.

Level of agreement at admissions predicted improvement at discharge. Expected helpfulness of staff however, did not. Agreement did not vary due to use of medication. Effects were found within the group of patients who received psychotropic agents. Greater agreement was associated with use of lower doses of antipsychotics, but higher doses of minor tranquilizers and antidepressants. No connection was found regarding lithium use. Patients' expectations of helpfulness had no effect on use of medication. Lieberman et al. suggest that larger doses of medication may be necessary to "correct" or "compensate" for a less-than optimal relationship between client and therapist. Patient-staff agreement was also associated with lack of precipitous discharge and a change in defensive style (a decrease in use of immature defenses). Lieberman et al. state that if the therapeutic alliance contributes to improvement, it seems probable that it is due to the ability of patients to share goals and to work collaboratively with the therapist.

Informing Clients

Dauser, Hedstrom and Croteau (1995) believe that client rights have been emphasized more in recent years. Prospective clients for therapy are generally provided with information about the process. By receiving written information about therapy before it begins, the client can make better decisions concerning entering therapy and choosing a therapist. A review of the literature identifies 12 such types of therapy information (Hedstrom & Ruckel, 1992): (a) therapy process or techniques; (b) services

provided and type of clients served; (c) expectations and anticipated results; (d) possible risks; (e) alternatives to therapy; (f) qualifications of therapist; (g) rights and limits of confidentiality (including third party issues); (h) length and frequency of sessions; (i) right to terminate treatment (or description of rights if involuntary); (j) cost and method of payment; (k) identification of supervisor, and (l) identification of board of licensing.

Therapists may not be providing all of this information in writing prior to treatment. There is concern that full disclosure may impede the therapeutic process. Research studies conducted by (Epperson & Lewis, 1987; Keating & Fretz, 1990; Lewis, Epperson, & Foley, 1989; Muehleman, Pickens, & Robinson, 1985) have investigated only a single aspect of disclosure, such as confidentiality or therapist values. Several studies demonstrated no significant effects of providing therapy information on such variables as counseling expectation, willingness to see a counselor, or perception of the therapist (Christiansen, 1986; Farley, 1987; Handelsman & Martin, 1992; Studwell, 1984).

This study builds on prior research by introducing the following methodological improvements: The information given covers all 12 areas, information is personalized to each therapist, actual clients are used in a field study design allowing measurement of actual client behaviors, and timing is such that client perceptions are measured before any exposuon of this study was that a pretherapy disclosure statement would have no effect on (a) client perceptions of therapists, (b) client opinions and attitudes toward therapy, and (c) actual client behaviors.

There were 63 participants in the study; divided into one group which received partial disclosure of information and one group which received full disclosure. The overall hypothesis was that no differential effects would be found between those clients who had partial disclosure and those who had full disclosure. The hypothesis was supported. The lack of negative effects of therapy disclosure concur with results from prior research. Limitations noted were: that there is a ceiling effect on the CRF-S instrument of measuring the differences in the degree of positiveness of perceptions of therapists, that all participants met with an intake counselor, and that results may not generalize to other settings.

Previous Research on Clients' Expectations

Satterfield, Buelow, Lyddon and Johnson (1995) argue that clients' readiness for change and clients' expectations about counseling are two factors that contribute to clients' entering, participating in, and benefitting from counseling. (McConnaughy et al., 1989) described four stages of change: clients in the precontemplation stage lack recognition that

a problem exists, clients in the contemplation stage recognize a problem and consider solutions, clients in the action stage are working toward change, clients in the maintenance stage are concerned with preventing relapse and maintaining changes. Client expectations can effect not only the process and outcome of counseling but also whether clients choose to enter counseling in the first place (H.E.A. Tinsley, Brown, de St. Aubin, & Lucek, 1984). H.E.A. Tinsley, Workman, & Kass (1980) identified four expectation factors: (a) Personal Commitment (the client's self-expectations about motivation, openness toward counseling, and responsibility in the process), (b) Facilitative Conditions (the client's expectations for acceptance, genuineness, trustworthiness, and confrontation, (c) Counselor Expertise (The client's expectation that the counselor will be knowledgeable, empathetic, and directive), and (d) Nurturance (the client's expectations for support and care from his or her counselor).

Satterfield, et al. noted that no prior research has examined the relationship between the stage of change model and client's expectations about counseling. Satterfield, et al. predicted that there would be significant associations between clients' expectations about counseling and their relative commitments to the four stages of change. There were 88 participants in this study. Measurements used were: the University of Rhode Island Change Assessment Scale, and the Expectations About Counseling-Brief Form.

The results imply that precontemplating clients may have lower expectations for counselor facilitative conditions of acceptance, genuineness, trustworthiness, and confrontation. Clients entering counseling in the contemplation and maintenance stages may have expectations for counselor responsibility in facilitating change. The results support the stage of change construct. Different stages of change may be meaningfully related to different client expectations.

Schneider, Beisenherz and Freyberger (1990) maintain that expectations and motivation are relevant to the therapeutic process for patients with chronic psychogenic, psychosomatic and organic diseases. Kunzel (1979) explored the relationship between the disorder and the motivation for therapy. Following the sociological model of deviation, the degree of impairment of the patient and the patient's control of the disorder are relevant to his motivation for psychotherapy. Schneider (1986) reflects motivation as a result of an interaction of affective and cognitive processes. The amount of suffering and the secondary gain from the illness are variables.

Schneider, Beisenherz, and Freyberger hypothesized that patients suffering from psychosomatic or somatic diseases will have relatively little motivation for psychotherapy. For the study different clinical groups were used. The group

with psychic diseases consisted of patients with neurotic disorders and various addictions. This group was compared with patients with dermatologic diseases as well as patients with functional complaints. The group of somatopsychic cases was taken from those patients with other non-specific dermatologic diseases. A questionnaire consisting of 47 items grouped into four subscales was given to 465 randomly selected patients.

The results supported their hypothesis. Patients with somatopsychic disorders have lower motivation for therapy, while neurotic patients with psychic symptoms present the highest motivation for psychotherapy. The researchers point out that the doctors may have handed the questionnaires out to patients whom they knew to be receptive to psychological treatment.

A multitude of theories concerning the importance of the client's expectations on the therapeutic process have been posed in years past. Frank (1959) felt that the client's expectations of therapy produced a placebo effect, contributing powerfully to treatment success. Apfelbaum (1958) argued that a client's expectations influenced both the effectiveness of communication within therapy and the effectiveness of therapy. Despite the apparent consensus, literature concerning expectations have noted the lack of evidence for such beliefs (Duckro, Beal, & George, 1979; Highlen & Hill, 1984; H.E.A. Tinsley, Bowman, &Ray, 1988; Wilkins, 1984). Most of the research that has been done has centered on the relation between personal characteristics and expectations of counseling (eg: Hardin & Yanico, 1983; Parham & Tinsley, 1980; Pecnik & Epperson, 1985; Yuen & Tinsley, 1981).

Tinsley, Bowman, and Barich (1993) decided to concentrate on the effects of unrealistic expectations of counseling on therapy. They surveyed the perceptions of counseling psychologists regarding the occurrence and effect of unrealistic expectations from their clients. A total of 72 practicing therapists were polled and they all had some clients that had unrealistic expectations. A survey which included 17 different expectations with the capacity to indicate whether the expectations were unrealistically low or high was given. Additionally, the therapists were asked to give their opinion as to whethdetrimental, or doesn't happen.

Although there were significant differences between the percentages of unrealistically high and low categories for the expectations, Personal Commitment, Counselor Expertise, and the Facilitative Conditions factors were found to be the most frequent of the unrealistic expectations. As the Tinsley, Bowman, and Barich put it " these counseling psychologists perceive their clients as most frequently underestimating the contribution they will be required to make to counseling and as overestimating the prowess of the

counselor and the presence of a facilitative environment" (p. 50). Also, the therapists indicated that they were of the opinion that unrealistically high or low expectations were detrimental to therapy.

Tinsley, Bowman, and Barich felt it was important to pursue the actual detrimental effects of unrealistic expectations, ways in which to modify the unrealistic expectations of clients, and investigations into curvilinear relations instead of mere linear ones. The mentioned strength of this study was the fact that practicing psychologists and their expert opinions were used in obtaining data. The potential for biases and subjective overtones is much lower when drawing from such a pool for a sample set.

The prospect of receiving psychotherapy may produce anxiety for those who are new to the experience. In psychotherapy, the experience of anxiety has been linked to a reduction in attendance to sessions (Noonan, 1973). Additionally, anxiety has been found to negatively correlated to patients' expectations about medical procedures (Cason, 1982). Zwick and Attkisson (1985) researched into the possible alleviation of anxiety via preparatory information provided prior to the actual therapy. They found that clients that were privy to such information had a greater symptom reduction after 1 month than the control group. Regardless of provided preparatory information, evidence indicates that client and therapist expectaty & Reznikoff, 1980; Duckro, Beal, & George, 1979).

Deane, Spicer, and Leathem (1992) conducted a study to determine the effects of videotaped preparatory information on expectations, anxiety, and the outcome of psychotherapy. While conducting more tests to cover for validity threats and pretest sensitization, they hypothesized: that preparatory information would increase the accuracy of clients' expectations, reduce pretherapy anxiety, and enhance outcomes after 2 months of therapy. Additionally, they posited that the effects of preparation on anxiety would be mediated by expectations but that any effects on either of these variables would have disappeared by the 2-month follow-up. Their results indicated that the preparatory information did help increase the accuracy of expectations and reduce anxiety, but it did not support their theory that they would mediate one another. Additionally, the outcomes of the experimental group were not enhanced by the preparatory information at the 2-month follow-up.

Deane et al. argued as Kazdin and Bass (1989) to account for their unsubstantiated hypotheses that the power of psychotherapy intervention studies to detect outcome effects is often weakened by inadequate sample sizes and by the size of expected differences relative to the general

effects of psychotherapy. Additionally, the length of follow-up was a 2-month period, whereas Zwick & Attisson (1985) had more promising results at a 1-month follow-up period. This may suggest that the effects of preparatory information were negligible after a 1-month period.

Preparatory information may also help influence the reduction in attendance to therapy sessions. Indeed, if it is able to positively effect either the therapeutic process or the outcome, it's use may be warranted for future success.

A clients' expectations of therapy may also be influenced by attitudes concerning the credibility of different therapeutic approaches. The effectiveness of psychotherapeutic treatments have been linked to their credibility (Borkovec & Nau, 1972; Morrison & Shapiro, 1987). Hypnosis is one such treatment that is particularly dependent upon the clients' expectation of benefit. There is also evidence that whether clients find treatments credible can effect the clients' use of the treatment mediums (Tinsley, Brown, de St. Aubin & Lucek, 1984). Additionally, social learning theory argues that clients' expectancies regarding the interaction and the roles of the therapist and client in the therapeutic process can influence the effectiveness of treatment (Frank, 1968; Tinsley & Harris, 1976). Furthermore, the clients' expectations of treatment outcome after the second session of therapy has been found to moderate treatment outcome but not the clients' initial expectancy (Perotti & Hopewell, 1980).

Hardy et al.(1995) were interested in determining if there was a difference in credibility of cognitive-behavioural therapy and psychodynamic-interpersonal therapy. They also wanted to research the effects of the credibility of a particular treatment on short-term outcome and if a clients' treatment principle credibility predicts the initial or emergent credibility of a treatment to which a client was randomly assigned.

The data used was drawn from a previous project that was conducted by a group of researchers in the Second Sheffield Psychotherapy Project (Shapiro, Barkham, Hardy & Morrison, 1990). Outcome and credibility measures were assessed via self-reports and a questionnaire.

The results indicated a difference in the credibility ratings of CB treatment versus the PI treatment in that clients rated the CB treatment as more credible. Although both ratings of credibility were above the average expected ratings and those who endorsed one type of treatment were likely to endorse the other. Also, the clients' perception of credibility was a significant predictor for treatment outcome for those that received the PI treatment alone, and for those that subscribed to the CB credibility prior to the PI treatment. CB treatment credibility was not

significantly correlated with improvement among clients who received CB treatment on any of the outcome measures.

Hardy et al. felt the difference in the CB and PI credibility and it's ability to predict treatment outcome was due to the difference in psychological knowledge required. CB treatments are more mediated by the therapist and the client must take a task-oriented role, whereas the PI treatments require a more analytical approach in which the client's success is largely due to their understanding of the psychological theory and practice used by the therapist. A clients' expectancies of therapeutic outcome is dependent on their perception of a treatment's credibility and it would be interesting to determine the intricacies of the interaction that takes place.

Accommodating Cultural Diversity

As the population of the United States has become increasingly diverse, there are increasing communicative and philosophical differences between cultural groups. In this multicultural society there is a need for counselors to be aware of the potential for misunderstanding during a counseling relationship. Understanding a minority client's expectations about counseling may help the counselor to deal with the client's fears (Atkinson & Gim, 1989; Yuen & Tinsley, 1981). Researchers have concluded that ethnic minorities in the United States often view the world differently than persons with a European heritage (Carter, 1990,1991; Ibrahim, 1991; Kluckhohn & Strodtbeck, 1961).

Several studies have focused on clients' preference for a counselor of the same ethnicity. The results have been mixed. African-American university students were found to have preferences for counselors of African heritage (Briley,1977; Grantham, 1970). Similar results were reported by Haviland, Horswill, O'Connel, and Dynneson (1983), though several other studies failed to find differences in clients' preferences for counselor ethnicity (Atkinson, Furlong, & Poston, 1986; Bernstein, Wade, & Hoffman, 1987; Tedeschi & Willis 1993).

Kenney investigated expectations about counseling as functions of ethnicity and presenting problem; the relationship between student ethnicity and preference for counselor ethnicity; and the relationship between student ethnicity and preference for counselor gender. Seventeen students (African-American, Asian-American, and European-American) completed a demographic questionnaire and were asked to state preferences for ethnicity and gender of counselors. The Expectations About Counseling-Brief Form (EAC-B; Hayes & Tinsley, 1989; Tinsley, 1982) inventory was utilized to assess students' expectancies.

More than three-quarters of the students preferred to see a counselor of the same ethnic background and this trend

was consistent across ethnic groups. There were no preferences regarding gender. African-Americans had the lowest expectations for facilitative conditions and counselor expertise. Asian international students expected less personal commitment than European-American students. Confounding factors given were: the extent to which the students realized the particular presenting problem assigned to them, and understood the differences between the interventions generally employed for each type of problem, educational status and previous mental health service utilization. Kenney cautions that these results are based on group differences; expectations of individuals may vary considerably. Kenney also recommends that ethnically diverse perspectives be incorporated into counselor training.

The main reasons clients seek outpatient psychotherapy.
Five Generic Client Objectives

Theoretically, clients can seek therapy for a multitude of idiosyncratic reasons. However, a previous factor analysis has suggested that there are certain regularities among clients that contribute to five common treatment objectives. When responses of new psychotherapy clients were analyzed, five main factors emerged. Clients were found to seek psychotherapy in order to change their perspective, their understanding, their decisions, their feelings, or their behavior. Distinguishing among these different therapeutic agendas is important in streamlining the helping process.

Psychotherapy can be conceptualized as addressing these five main client objectives. The first involves determining whether or not a given problem actually exists, and whether its magnitude is sufficient to warrant special attention. Our society's open, relativistic discussions about the wide range of human experience fail to provide some people with a clear sense of what is appropriate. While some find this relieving, and conclude that anything goes, others drift uneasily. Without clear boundaries, private fears can incubate. Casual use of diagnostic nomenclature fuels these self doubts (my boss said my desk looked "compulsively" organized...is there something wrong with me?). Popularly publicized norms of self-reported sexual experience from questionable surveys invite disturbing comparisons. Televised portrayals of "dysfunctional families", that seem eerily familiar, prompt more questions. It can be hard to know whether You're Okay. Many clients use therapy to compare their experiences with a yardstick of normality they assume the therapist possesses. They are interested in gauging how unusual or deviant their experience of distress is, and reaching a decision about whether or not their life is enough of a mess to warrant changes. They may use therapy to measure the severity of their problems in living,

and to specify the serious stumbling blocks they are confronting.

Psychotherapy can also be used as a tool for fashioning an intellectually satisfying, cogent, plausible explanation for the circumstances of one's life. Clients often use therapy to address their need to understand and make sense of themselves and their relationships. Therapy offers a broad menu of explanatory options, and clients with this second agenda will usually be happiest when a therapist succeeds in creating a credible story of causation that simplifies complex and confusing phenomena in a way that restores the client's sense of control and optimism. We say usually, because some clients seem perversely drawn to very lengthy, elaborate, intricate, even counterintuitive tales of origin, that seem to cast them as enduring victims. This is consistent with the observation that some clients seem to expect from therapy little beyond a compelling explanation for their pain. They evaluate therapy and their therapist very positively, despite the fact that their symptoms remain intact. Increasing the client's sense of having a grasp on things may be all a client seeks. Sometimes, clients use this self-discovery process as a way of stalling change. It is often far less threatening to figure out why you're in the mess you're in than to change the mess. This is especially true if manipulating words and abstractions comes easily for a client. Creating a life story that expiates and serves defensive needs for self flattery is particularly reinforcing for many clients.

The third need that clients may present involves deciding whether or not to they should make changes. After a client makes the determination that their life is a mess, they still must assess whether or not they really want to do anything about it. Making the decision to change is frequently extremely difficult, because few life situations are clear-cut; the status quo offers both advantages and disadvantages, and the future looms unseen and untested. Judging amorphous circumstances and evaluating unpredictable consequences is both intellectually and emotionally demanding. Change requires courage; yet, capricious, impulsive change is stupid. No wonder therapists often grow impatient with clients making this third use of treatment. The process can take a lot of time. Also, no wonder so many clients prefer instead to follow the quest for a cleaner and cleaner autobiographical account, rather than to decide whether and when to jump. The decision to change requires an acceptance of personal responsibility many people prefer to shirk.

The fourth and fifth needs that drive clients to therapy involve their need for assistance in implementing their decision to change. Many want to learn techniques for managing their feelings more constructively. They want to change their affective experiences, and are asking for

expert guidance in so doing.

The fifth need revolves around the desire to implement behavioral changes. Here clients seek specific suggestions about how to stop drinking, get along with their children, negotiate with their spouses, find a better job, etc. They approach the professional as an expert in living, and employ their therapist to teach them techniques that will make changing more efficient and pleasant. Historically, therapists have been rather suspicious of clients baldly asking for this kind of help and guidance. Such obvious dependence on others may trigger therapists' own counterdependent ambivalence about seeking help, or therapists may fear creating a "patient for life" if they indulge needs for gratification. Clients who seek direct advice are also sometimes frustrated on the grounds that fulfilling their requests would stymie the clients' self actualization. It's assumed that discovering answers on your own is empowering and fosters greater confidence and internal directedness. However, clients tg advice. They believe our role is to consult with them and recommend appropriate plans of attack to use in their battles to make their lives more satisfying. We should hardly be surprised when many clients look aghast when told that we don't offer "quick fixes". That's what they want. And in reality we now do have some of the technologies they're after. Although far from perfect, the behaviorists, cognitivists, NLP folks, and others have developed tools that can expedite change. These should be shared with clients who are eager to learn, and shared promptly (before their willingness to experiment passes!). Clients should be given the type of brief problem solving therapy their needs warrant in these cases.

Five Common Client Agendas

1.Normalization
2.Analysis
3.Decision-making
4.Feelings Modification
5.Behavior Skills

1. Normalization

Do I Have a real problem?
Am I normal?
Do I have to make changes?
Should I be making changes?

Many clients come to therapy seeking comparison with norms. The married father of three with a longstanding relationship with a girlfriend on the side, who wonders if he should be getting a divorce. The gay thirty-something

client who puzzles over whether it would be wiser to try to live out a straight lifestyle. Their current ways of living may be working in many respects, but associated with an underlying sense of inappropriateness that creates nagging doubts about the wisdom of their choices.

Clients seeking this kind of attitudinal change are often terrified by the notion that they are somehow deviant, and consequently unacceptable. Such clients come to therapy looking for reassurance from an expert whose judgment about behavioral norms they feel they can trust. They want to find out for once and for all whether their conduct lies outside the limits of acceptability, and they share their private secrets in the desperate hope that their therapist has heard this all many, many times before. These clients want validation and acceptance, in order to modify their self-view and their anxiety about their conduct. They may not really want to change any more than that. Such clients may be experiencing a vague sense that life is more difficult and stressful than they had expected it would be, and find that they have an ongoing struggle with self-doubt. They need to hear that this is all normal, that life is tough for everyone at times. When this goal is primary, by termination the client hopes mainly to have changed his mind, and to have concluded that his problems are within the normal range, and that perhaps he's doing about as well as can be expected, given the circumstances of his life. Many of these clients are not genuinely motivated to make other types of changes, and open-ended efforts with those aims won't work and are arguably inappropriate.

2.Analysis

Why Am I Like This?
How Did I Get To Be This Way?
What Made Me This Kind Of Person?

Other clients are seeking to make their experience of their lives more meaningful and coherent, and are therefore interested in therapy that will help them in fashioning a more clear and credible story about who they are and how they got that way. Making sense of the pain changes it, and can make it more bearable. When this goal is the priority, clients may relish either a brand new, mysterious and intriguing explanation that had never occurred to them (that's what I'm paying you for!), or to have their own pet explanation refined and given legitimacy. A convincing causal story can make life seem more predictable and can enhance feelings of control. Some explanations exonerate clients, reducing their guilt and self-blame. Most people enjoy trying to figure themselves out, and therapists usually find the creative process of generating a convincing developmental tale a fascinating challenge. Since most

therapists use the client's corroboration as proof of the therapist's theory's accuracy, (and clients tend to want to keep their therapists happy, and so they accordingly agree with most offered theories) doing this kind of work can leave the therapist feeling very brilliant indeed.

Some clients just want company in their search for an internally consistent personal history; their quest is to understand why they are the way they are, and why they do the things they do. That's it. They may not genuinely want to make any other changes.

Critics of many historical and insight-oriented therapeutic approaches have indicted therapists who offer clients little more than a plausible explanation of their lives, assuming that all clients need and desire far more. But it would be wrong to overlook those clients who are simply seeking a good story of self. They are quite well suited to certain open-ended insight therapies, and may experience considerable personal growth as a result of this therapeutic process. However, it probably is legitimate to question whether lengthy work of this type should be subsidized by insurance.

3.Decision-making

What Should I Do?
What Course Makes the Most Sense?
What's the Best Decision?

Many clients seek therapy in order to get help in making an important life decision. They are at a crossroad, and believe that their therapist's expertise will allow them to reduce the probability of making a costly life mistake. These ambivalent clients assume that the therapist's knowledge about the options they are facing is superior to their own. Their hope is that the therapist will either guide them to make the right choice, or at least expedite the process of choosing. Many clients believe they will learn some special technique for weighing various alternative courses of action and making a choice about the most advantageous path. They assume that the therapeutic process will speed up their deliberations, and help to resolve their ambivalence. They believe that therapists have a wealth of knowledge about human experience that allows them to inform their clients about the probable outcomes associated with the various paths they are contemplating. By the end of therapy, these clients want to have made a difficult decision and to have confidence in their final choice. Shortterm, solution-focused approaches seem the most appropriate in these cases, although more research on facilitating clients' decision making is needed.

4.Feelings Modification

Can You Help Me Feel Better?
How Can I Ease My Distress?

Many clients are primarily interested in altering their affective experience. They want to feel better, and are open to trying a wide variety of things if they can be persuaded that such experiments will reduce negative affect. A wide spectrum of specific, focused therapeutic techniques have been developed to address the needs of these clients.

5.Behavior Skills

How Do I Do That?
What's the Best Way to Do That?

Last are the many clients who want to change what they're doing. Clients frequently present therapists with behavioral symptoms they want to give up; at other times clients quickly realize that the other changes they desire (e.g., in how they feel) are only achievable by altering their actions. When this goal dominates, clients are asking for education about how to implement the changes they've already decided they want to make. They need help in executing their choices, because they lack information, confidence, or skills. By the end of treatment, they want to be acting differently in particular situations. Here too, myriad specific techniques of demonstrated efficacy are available.

The Importance of Clients' Objectives

It is vital to stay attuned to the client's desired objective throughout treatment, because this not only provides a yardstick for evaluating treatment efficacy, but also should frame the selection of therapeutic interventions. Clarity about what the client desires allows therapists to circumvent much resistance. It can guide how every minute of the session is used, and how the therapist allocates his attention. It can shape how therapists phrase their comments, in order to make them maximally influential. The client's objectives should shape the process and outcome measures used to evaluate treatment efficacy.

METHOD

One hundred randomly selected mental health care professionals were asked to record their responses on a questionnaire with 27 Likert-format items concerning clients' attitudes toward therapy (see Appendix A). The mental health care professionals were asked to answer the

questions as they felt a new client would be likely to answer them. They were invited to make copies of the questionnaire and have new clients respond to the questions. A second sample of prospective psychotherapy clients was obtained by anonymously surveying undergraduates at a small Liberal Arts college. A separate demographic questionnaire was provided for the therapist and the client. Respondents were assured of anonymity. The therapist demographic questionnaire consisted of 6 items. The client questionnaire consisted of 4 items. Names and addresses of health care professionals were selected from telephone directories and through direct professional contacts. Responses were obtained from 7 therapists and 42 prospective clients, primarily from urban and suburban communities in the Mid-Atlantic region.

Results

A sample size of 50 clients (21 males, 28 females) responded to the questionnaire. The clients' mean age was 23.10 yr. (range, 12-60 years). Of 100 therapists contacted, seven responded to the questionnaire.

Between group t-tests were performed to compare the responses of prospective clients and therapists. No significant differences were found on 22 of 26 items. Therapists perceived feeling more positive and learning how to handle situations more competently as more important than clients. Results showed a trend for therapists to also rate the desire of clients to feel less anxious and to develop a better relationship with family as more important than did clients.

Table 1

Responses regarding reasons for seeking treatment

	Therapist		Client	
	M	SD	M	SD
Feel more positive**	3.14	.69	2.49	1.12
Learn to handle situations**	3.14	.69	2.49	1.05
Feel less anxious and depressed*	3.43	.79	2.77	.95
Improved family relations*	2.86	.90	2.12	.98

** $p<.05$
* $p<.08$

Scores for each of the 5 goal categories (analysis, normal, decision, behavior, & feeling) were calculated for each subject by summarizing relevant items.

When therapists' and clients' responses on the 5 summary measures were compared using t-tests, no significant differences emerged. However, there was a tendency for therapists to rate behavioral change more highly than clients did.

Table 2

Responses of clients regarding goal categories

	M	SD
Normalization	11.58	4.12
Analysis	12.79	3.21
Decision-making	12.35	3.54
Feelings Modification	11.74	3.65
Behavior Skills	12.40	3.81

Table 3

Responses of therapists regarding goal categories of clients

	M	SD
Normalization	10.57	1.51
Analysis	12.43	3.26
Decision-making	13.43	3.31
Feelings Modification	13.00	2.16
Behavior Skills	14.71	3.40

Whithin subject t-tests comparing scores on the 5 goal categories reveal two significant differences. Scores on the normalization factor ($x = 11.44$; s.d. = 3.87) were significantly lower ($p < .05$) than those on behavior change ($x = 12.72$; s.d. = 3.81) and analysis ($x = 12.74$; s.d. = 3.19).

Clients were asked to identify a term that they feel most comfortable with regarding the therapists' perception of the client. The result was that 34% prefer to be referred to as a client, 34% prefer the term patient, and 12% prefer to be regarded as a consumer.

The responding clients were also asked how they view the relationship between client and therapist. The majority (42%) think of the therapist as an advisor, 30% as a confidant, and 10% view the therapist as a friend.

Discussion

Overall, therapists and clients rated therapy goals similiarly. The two groups disagreed on only four of the twenty-six items. This suggests that therapists generally

have an accurate view of what their clients are seeking from treatment. Congruence in expectancies does not necessarily mean that the therapist and client are actively or effectively meeting those expectations. This is consistent with findings discussed previously indicating that premature termination often results from therapists' failure to meet client's goals efficiently.

While, all five goal categories were endorsed, for both therapists and clients, scores were higher for behavior change and analysis than for normalization. This suggests that although seeing one's troubles as normative may often be desirable and reassuring, this is not one of the primary things clients hope to obtain as a result of treatment.

The present study was limited by its small sample size and use of prospective rather than actual clients. Replication using a larger, more clinically representative sample would be useful.

Appendix A

Client Attitude Questionnaire (CAQ): Please share your reasons for coming to counseling by responding to the following items. (1=not at all 2=somewhat 3=very true 4=extremely true)

1. I hope therapy will increase my understanding of why I do things. (A)
2. I hope to discover that my feelings aren't very unusual. (N)
3. I hope to feel less anxious and depressed. (F)
4. I want to be able to make the right choice about what to do. (D)
5. I want to find out if I have a serious problem. (N)
6. I want to know the reasons behind my actions and feelings. (A)
7. I hope to learn how to be more effective in relating to others. (B)
8. I want to have more confidence that I can do things. (B)
9. I need help in learning how to make better decisions. (D)
10. I need help in understanding how my childhood influenced me. (A)
11. I need help in learning how to be more assertive. (B)
12. I want to feel more positive about myself. (F)
13. I want to learn how to handle situations more competently. (B)
14. I hope to learn how to be more honest with myself. (A)
15. I need to learn how to relax and have more fun. (F)
16. I want to learn whether other people have problems like mine. (N)
17. I want to learn how to prevent becoming depressed. (F)
18. I need some practical advice about a choice I'm facing. (D)
19. I hope to figure out what makes me tick. (A)
20. I want to learn how to get along better with my family now. (B)
21. I need to know if I'm the only one going through this. (N)
22. I need help in deciding what to do with my life. (D)
23. I need to learn how to keep from getting too angry. (F)
24. I want to figure out the course that will make me most happy. (D)
25. I want to find out if my problems are common. (N)

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Clients' Motivations for Seeking Treatment

The Client Attitude Questionnaire (CAQ) was developed to assess the reasons clients seek the help of a psychotherapist. It was designed to measure five different motivations for entering treatment, and is intended for use in both research and as a tool for clinicians in deciding how to structure their treatment.

The following shows the five factors and the items with the highest loadings on each of these factors. The 25 scale items were selected from an original pool of 40, on the basis of a factor analysis conducted on data from a sample of 140 therapy clients obtained over a period of four years.

Factor analytic research can be used to collapse scales, reducing items without any significant loss of information. Shortened forms impose less of a burden on the recipients, and are therefore expected to yield higher response rates. On-site evaluation provides clinicians with immediate feedback on their clients' expectations of treatment.

Normalization

I want to find out if I have a serious problem.

I hope to discover that my feelings aren't very unusual.

I want to learn whether other people have problems like mine.

I need to know if I'm the only one going through this.

I want to find out if my problems are common.

Analysis

I hope therapy will increase my understanding of why I do things.

I want to know the reasons behind my actions and feelings.

I need help in understanding how my childhood influenced me.

I hope to figure out what makes me tick.

I hope to learn how to be more honest with myself.

Feelings

I hope to feel less anxious and depressed.

I want to feel more positive about myself.

I need to learn how to relax and have more fun.

I want to learn how to prevent becoming depressed.

I need to learn how to keep from getting too angry.

Decision-making

I want to be able to make the right choice about what to do.

I need help in learning how to make better decisions.

I need help in deciding what to do with my life.

I need some practical advice about a choice I'm facing.

I want to figure out the course that will make me most happy.

Behavior Skills

I hope to learn how to handle situations more competently.

I want to have more confidence that I can do things.

I need help in learning how to be more assertive.

I hope to learn how to be more effective in relating to others.

I want to learn how to get along better with my family now.

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